90 DEGREE BENEFITS
A Turn For The Better

SIMPLE DENTAL
DENTAL & VISION PLANS

Dental Claim Form – Submitted by Employee

Employer_____

Group #_____

Employee:_____

Social Security No_____-_____-_____Member ID_____Birth Date _____

Address_____

City_____State_____Zip_____

Phone No_____E-mail_____

Has your address changed since your last claim? ☐ **Yes** ☐ No

Patient Name_____

Relationship to Employee:_____Birth Date: _____

Dentist_____

Phone No._____

Address_____

City_____State_____Zip _____

Please attach a copy of the original, itemized bill. The claim will not be processed without it.

Under penalty of law, I agree to the following:
This claim occurred while the patient was covered by this plan. The attached bill is an original, unaltered bill.

Employee Signature_____Date _____

FOR FASTEST SERVICE PLEASE HAVE YOUR PROVIDER SUBMIT CLAIM ELECTRONICALLY TO PAYER ID #58102.

YOU MAY ALSO FAX OR MAIL THIS FORM AND SUPPORTING DOCUMENTATION TO:

Fax to:
1-888-308-6009

Or mail to:
Simple, 2810 Premiere Pkwy, Ste. 400, Duluth, GA 30097

Customer Service: 800-270-4158

REMEMBER TO INCLUDE A COPY OF THE ORIGINAL, ITEMIZED BILL, AND ANY EXPLANATION OF BENEFITS FROM YOUR PRIMARY DENTAL CARRIER.

Keep a copy for your records.